

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-044451

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 224

FILED NOV 22 1963

1. PLACE OF DEATH a. COUNTY JASPER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY JASPER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CARTHAGE		c. CITY OR TOWN CARTHAGE	
Length of stay in 1b 5 YRS.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MCCUNE BROOKS HOSPITAL		d. STREET ADDRESS (If outside, give location) 108 MERIDIAN	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First HENRY Middle JACKSON Last HOLLOWAY		4. DATE OF DEATH Month Nov. Day 11 Year 1963	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/16/01
9. AGE (last birthday) 62		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE	
11. BIRTHPLACE (City and state or country) CENTER RIDGE, ARK.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME ERWIN HOLLOWAY		13b. MOTHER'S MAIDEN NAME LUCINDA MCCUIN	
14. NAME OF HUSBAND OR WIFE JULIA JOHNSON HOLLOWAY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Address MRS. JULIA J. HOLLOWAY, CARTHAGE, MO	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse Pulmonary Fibrosis and Emphysema		INTERVAL BETWEEN ONSET AND DEATH Years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cor Pulmonale and Old Tuberculosis right lung		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from 12-19-61 to 11-11-63 and last saw him alive on 11-10-63 Death occurred at 11:26 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Richard R. Coyle</i> (Degree or title)		22b. ADDRESS M.D. 116 W. THIRD, CARTHAGE, MO.	
22c. DATE SIGNED 11-13-63			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11/13/63	23c. NAME OF CEMETERY OR CREMATORY OAK HILL CEMETERY	
23d. LOCATION (City, town, or county) CARTHAGE, MISSOURI		(State)	
24. FUNERAL DIRECTOR ADDRESS ULMER FUNERAL HOME, CARTHAGE, MO.		25. DATE RECD. BY LOCAL REG. 11-13-63	
26. REGISTRAR'S SIGNATURE <i>Ely Clinton</i>			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

DATE AMENDED

VS 300
Rev. 4/59

10497

20497

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NOV 26 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Melvin Garrett

Licensed Embalmer No. 5121

P. O. Address CARTHAGE, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.